NEW PATIENT HEALTH QUESTIONNAIRE

Full Name: ……………………………………..……….. Date of Birth: ……………………………………

Home Telephone No: …………………………………..Mobile No: ………………………………………..

Can you give a contact name & telephone number for someone in this country that we could contact in an

Emergency:

Name: ……………………………………………Telephone No: ……………………………………………..

[ ] Spouse [ ] Partner [ ] Relative [ ] Friend

Do you help look after a Friend or Relative? [ ] No [ ] Yes ……………………………………………………
(Please specify who)

Are you yourself looked after by a Friend or Relative? [ ] No [ ] Yes …………………………………….
(Please specify who + Tel No)

Smoking Status

[ ] Current Smoker [ ] Ex-Smoker [ ] Never Smoked

If you are a Current or Ex-Smoker please tick and complete where appropriate below: -

[ ] Cigarettes [ ] Cigars How Many? …… [ ] Rolls Own [ ] Pipe Oz Per week? ....

If Ex-Smoker please tell us when you stopped i.e. Month/Year _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Please tick box if you have ever suffered from any of the following. If you take regular medication you will need to book an appointment for a "New Patient Check" with the Nurse.

[ ] Cancer

[ ] Heart Disease / Heart Attack / Angina / Chest Pain

[ ] Stroke / Mini Stroke / TIA

[ ] Asthma / COPD / Use Inhalers / Emphysema

[ ] Raised Blood Pressure

[ ] Diabetes

[ ] Kidney Problems

[ ] Shortness of Breath

[ ] Raised Blood Sugar Levels

[ ] Depression/Anxiety

NHS England **THE FOREST HILL ROAD GROUP PRACTICE**